

## Centers for Medicare & Medicaid Services, HHS

## § 440.2

facility services for individuals age 65 or older in institutions for mental diseases.

440.150 Intermediate care facility (ICF/MR) services.

440.155 Nursing facility services, other than in institutions for mental diseases.

440.160 Inpatient psychiatric services for individuals under age 21.

440.165 Nurse-midwife services.

440.166 Nurse practitioner services.

440.167 Personal care services.

440.168 Primary care case management services.

440.169 Case management services.

440.170 Any other medical or remedial care recognized under State law and specified by the Secretary.

440.180 Home or community-based services.

440.181 Home and community-based services for individuals age 65 or older.

440.185 Respiratory care for ventilator-dependent individuals.

### Subpart B—Requirements and Limits Applicable to All Services

440.200 Basis, purpose, and scope.

440.210 Required services for the categorically needy.

440.220 Required services for the medically needy.

440.225 Optional services.

440.230 Sufficiency of amount, duration, and scope.

440.240 Comparability of services for groups.

440.250 Limits on comparability of services.

440.255 Limited services available to certain aliens.

440.260 Methods and standards to assure quality of services.

440.270 Religious objections.

### Subpart C—Benchmark Benefit and Benchmark-Equivalent Coverage

440.300 Basis.

440.305 Scope.

440.310 Applicability.

440.315 Exempt individuals.

440.320 State plan requirements: Optional enrollment for exempt individuals.

440.325 State plan requirements: Coverage and benefits.

440.330 Benchmark health benefits coverage.

440.335 Benchmark-equivalent health benefits coverage.

440.340 Actuarial report for benchmark-equivalent coverage.

440.345 EPSDT services requirement.

440.350 Employer-sponsored insurance health plans.

440.355 Payment of premiums.

440.360 State plan requirement for providing additional wrap-around services.

440.365 Coverage of rural health clinic and federally qualified health center (FQHC) services.

440.370 Cost-effectiveness.

440.375 Comparability and scope of coverage.

440.380 Statewideness.

440.385 Freedom of choice.

440.390 Assurance of transportation.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45224, Sept. 29, 1978, unless otherwise noted.

## Subpart A—Definitions

### § 440.1 Basis and purpose.

This subpart interprets and implements the following sections of the Act:

1902(a)(70), State option to establish a non-emergency medical transportation program.

1905(a) Services included in the term “medical assistance.”

1905 (c), (d), (f) through (i), (l), and (m) Definitions of institutions and services that are included in the term “medical assistance.”

1913 “Swing-bed” services. (See §§ 447.280 and 482.66 of this chapter for related provisions on “swing-bed” services.)

1915(c) Home and community-based services listed as “medical assistance” and furnished under waivers under that section to individuals who would otherwise require the level of care furnished in a hospital, NF, or ICF/MR.

1915(d) Home and community-based services listed as “medical assistance” and furnished under waivers under that section to individuals age 65 or older who would otherwise require the level of care furnished in a NF.

[57 FR 29155, June 30, 1992, as amended at 61 FR 38398, July 24, 1996; 73 FR 77530, Dec. 19, 2008]

### § 440.2 Specific definitions; definitions of services for FFP purposes.

(a) *Specific definitions.*

*Inpatient* means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who—

(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later

## § 440.10

develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

*Outpatient* means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

*Patient* means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain. (See also § 435.1010 of this chapter for definitions relating to institutional care.)

(b) *Definitions of services for FFP purposes.* Except as limited in part 441, FFP is available in expenditures under the State plan for medical or remedial care and services as defined in this subpart.

[43 FR 45224, Sept. 29, 1978, as amended at 52 FR 47934, Dec. 17, 1987; 71 FR 39229, July 12, 2006]

## § 440.10 Inpatient hospital services, other than services in an institution for mental diseases.

(a) *Inpatient hospital services* means services that—

(1) Are ordinarily furnished in a hospital for the care and treatment of inpatients;

(2) Are furnished under the direction of a physician or dentist; and

(3) Are furnished in an institution that—

(i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

(iii) Meets the requirements for participation in Medicare as a hospital; and

(iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary.

## 42 CFR Ch. IV (10–1–09 Edition)

(b) Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing-bed approval.

[47 FR 21050, May 17, 1982, as amended at 47 FR 31532, July 20, 1982; 51 FR 22041, June 17, 1986; 52 FR 47934, Dec. 17, 1987; 60 FR 61486, Nov. 30, 1995]

## § 440.20 Outpatient hospital services and rural health clinic services.

(a) *Outpatient hospital services* means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that—

(1) Are furnished to outpatients;

(2) Are furnished by or under the direction of a physician or dentist; and

(3) Are furnished by an institution that—

(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

(ii) Meets the requirements for participation in Medicare as a hospital; and

(4) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of “outpatient hospital services” those types of items and services that are not generally furnished by most hospitals in the State.

(b) *Rural health clinic services.* If nurse practitioners or physician assistants (as defined in § 481.1 of this chapter) are not prohibited by State law from furnishing primary health care, “rural health clinic services” means the following services when furnished by a rural health clinic that has been certified in accordance with part 491 of this chapter.

(1) Services furnished by a physician within the scope of practice of his profession under State law, if the physician performs the services in the clinic or the services are furnished away from the clinic and the physician has an agreement with the clinic providing that he will be paid by it for such services.

(2) Services furnished by a physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner (as defined in §§ 405.2401 and 491.2 of this chapter) if the services are furnished in accordance with the

## Centers for Medicare & Medicaid Services, HHS

## § 440.40

requirements specified in § 405.2414(a) of this chapter.

(3) Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See §§ 405.2413 and 405.2415 of this chapter for the criteria for determining whether services and supplies are included under this paragraph.)

(4) Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

(i) The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see § 405.2417 of this chapter);

(ii) The services are furnished by a registered nurse or licensed practical nurse or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic;

(iii) The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

(iv) The services are furnished to a homebound recipient. For purposes of visiting nurse care, a “homebound” recipient means one who is permanently or temporarily confined to his place of residence because of a medical or health condition. He may be considered homebound if he leaves the place of residence infrequently. For this purpose, “place of residence” does not include a hospital or a skilled nursing facility.

(c) *Other ambulatory services furnished by a rural health clinic.* If the State plan covers rural health clinic services, other ambulatory services means ambulatory services other than rural health clinic services, as defined in paragraph (b) of this section, that are otherwise included in the plan and meet specific State plan requirements for furnishing those services. Other ambulatory services furnished by a rural health clinic are not subject to the physician supervision requirements

specified in § 491.8(b) of this chapter, unless required by State law or the State plan.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 21050, May 17, 1982; 52 FR 47934, Dec. 17, 1987; 60 FR 61486, Nov. 30, 1995; 73 FR 66198, Nov. 7, 2008; 74 FR 31195, June 30, 2009]

### § 440.30 Other laboratory and X-ray services.

Other laboratory and X-ray services means professional and technical laboratory and radiological services—

(a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law or ordered by a physician but provided by referral laboratory;

(b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and

(c) Furnished by a laboratory that meets the requirements of part 493 of this chapter.

[46 FR 42672, Aug. 24, 1981, as amended at 57 FR 7135, Feb. 28, 1992]

### § 440.40 Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease), EPSDT, and family planning services and supplies.

(a) *Nursing facility services.* (1) “Nursing facility services for individuals age 21 or older, other than services in an institution for mental diseases”, means services that are—

(i) Needed on a daily basis and required to be provided on an inpatient basis under §§ 409.31 through 409.35 of this chapter.

(ii) Provided by—

(A) A facility or distinct part (as defined in § 483.5(b) of this chapter) that meets the requirements for participation under subpart B of part 483 of this chapter, as evidenced by a valid agreement between the Medicaid agency and the facility for providing nursing facility services and making payments for services under the plan; or

(B) If specified in the State plan, a swing-bed hospital that has an approval from CMS to furnish skilled nursing facility services in the Medicare program; and

#### § 440.50

(iii) Ordered by and provided under the direction of a physician.

(2) Nursing facility services include services provided by any facility located on an Indian reservation and certified by the Secretary as meeting the requirements of subpart B of part 483 of this chapter.

(b) *EPSDT*. “Early and periodic screening and diagnosis and treatment” means—

(1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and

(2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. (See subpart B of part 441 of this chapter.)

(c) *Family planning services and supplies for individuals of child-bearing age*. [Reserved]

[59 FR 56233, Nov. 10, 1994; 60 FR 50117, Sept. 28, 1995, as amended at 61 FR 59198, Nov. 21, 1996; 68 FR 46071, Aug. 4, 2003]

#### § 440.50 Physicians’ services and medical and surgical services of a dentist.

(a) “Physicians’ services,” whether furnished in the office, the recipient’s home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician—

(1) Within the scope of practice of medicine or osteopathy as defined by State law; and

(2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

(b) “Medical and surgical services of a dentist” means medical and surgical services furnished, on or after January 1, 1988, by a doctor of dental medicine or dental surgery if the services are services that—

(1) If furnished by a physician, would be considered physician’s services.

(2) Under the law of the State where they are furnished, may be furnished either by a physician or by a doctor of dental medicine or dental surgery; and

(3) Are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnished the services.

[56 FR 8851, Mar. 1, 1991]

#### 42 CFR Ch. IV (10–1–09 Edition)

#### § 440.60 Medical or other remedial care provided by licensed practitioners.

(a) “Medical care or any other type remedial care provided by licensed practitioners” means any medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.

(b) Chiropractors’ services include only services that—

(1) Are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under § 405.232(b) of this chapter; and

(2) Consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

#### § 440.70 Home health services.

(a) “Home health services” means the services in paragraph (b) of this section that are provided to a recipient—

(1) At his place of residence, as specified in paragraph (c) of this section; and

(2) On his or her physician’s orders as part of a written plan of care that the physician reviews every 60 days, except as specified in paragraph (b)(3) of this section.

(b) Home health services include the following services and items. Those listed in paragraphs (b) (1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.

(1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who—

(i) Is currently licensed to practice in the State;

(ii) Receives written orders from the patient’s physician;

(iii) Documents the care and services provided; and

(iv) Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.

(2) Home health aide service provided by a home health agency,

(3) Medical supplies, equipment, and appliances suitable for use in the home.

(i) A recipient's need for medical supplies, equipment, and appliances must be reviewed by a physician annually.

(ii) Frequency of further physician review of a recipient's continuing need for the items is determined on a case-by-case basis, based on the nature of the item prescribed;

(4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (See § 441.15 of this subchapter.)

(c) A recipient's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded, except for home health services in an intermediate care facility for the mentally retarded that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a recipient in an intermediate care facility for the mentally retarded during an acute illness to avoid the recipient's transfer to a nursing facility.

(d) "Home health agency" means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare, including the capitalization requirements under § 489.28 of this chapter.

(e) A "facility licensed by the State to provide medical rehabilitation services" means a facility that—

(1) Provides therapy services for the primary purpose of assisting in the rehabilitation of disabled individuals through an integrated program of—

(i) Medical evaluation and services; and

(ii) Psychological, social, or vocational evaluation and services; and

(2) Is operated under competent medical supervision either—

(i) In connection with a hospital; or

(ii) As a facility in which all medical and related health services are prescribed by or under the direction of in-

dividuals licensed to practice medicine or surgery in the State.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980; 62 FR 47902, Sept. 11, 1997; 63 FR 310, Jan. 5, 1998]

#### § 440.80 Private duty nursing services.

*Private duty nursing services* means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided—

(a) By a registered nurse or a licensed practical nurse;

(b) Under the direction of the recipient's physician; and

(c) To a recipient in one or more of the following locations at the option of the State—

(1) His or her own home;

(2) A hospital; or

(3) A skilled nursing facility.

[52 FR 47934, Dec. 17, 1987]

#### § 440.90 Clinic services.

*Clinic services* means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(a) Services furnished at the clinic by or under the direction of a physician or dentist.

(b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

[56 FR 8851, Mar. 1, 1991, as amended at 60 FR 61486, Nov. 30, 1995]

#### § 440.100 Dental services.

(a) "Dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of—

(1) The teeth and associated structures of the oral cavity; and

## § 440.110

## 42 CFR Ch. IV (10–1–09 Edition)

(2) Disease, injury, or impairment that may affect the oral or general health of the recipient.

(b) “Dentist” means an individual licensed to practice dentistry or dental surgery.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980]

### § 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) *Physical therapy.* (1) *Physical therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A “qualified physical therapist” is an individual who is—

(i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and

(ii) Where applicable, licensed by the State.

(b) *Occupational therapy.* (1) *Occupational therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A “qualified occupation therapist” is an individual who is—

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

(c) *Services for individuals with speech, hearing, and language disorders.* (1) *Services for individuals with speech, hearing, and language disorders* means diagnostic, screening, preventive, or cor-

rective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

(2) A “speech pathologist” is an individual who meets one of the following conditions:

(i) Has a certificate of clinical competence from the American Speech and Hearing Association.

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate.

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(3) A “qualified audiologist” means an individual with a master’s or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:

(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services.

(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions:

(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.

(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master’s or doctoral degree in audiology, or a related field; and successfully completed

a national examination in audiology approved by the Secretary.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980; 56 FR 8854, Mar. 1, 1991; 60 FR 19861, Apr. 21, 1995; 69 FR 30587, May 28, 2004]

**§ 440.120 Prescribed drugs, dentures, prosthetic devices, and eyeglasses.**

(a) “Prescribed drugs” means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are—

(1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law;

(2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

(3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist’s or practitioner’s records.

(b) “Dentures” are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

(c) “Prosthetic devices” means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to—

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

(d) “Eyeglasses” means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.

**§ 440.130 Diagnostic, screening, preventive, and rehabilitative services.**

(a) “Diagnostic services,” except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or ex-

tent of illness, injury, or other health deviation in a recipient.

(b) “Screening services” means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

(c) “Preventive services” means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to—

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

(d) “Rehabilitative services,” except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

**§ 440.140 Inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for mental diseases.**

(a) *Inpatient hospital services.* “Inpatient hospital services for individuals age 65 or older in institutions for mental diseases” means services provided under the direction of a physician for the care and treatment of recipients in an institution for mental diseases that meets the requirements specified in § 482.60(b), (c), and (e) of this chapter and—

(1) Meets the requirements for utilization review in § 482.30(a), (b), (d), and (e) of this chapter; or

(2) Has been granted a waiver of those utilization review requirements under section 1903(i)(4) of the Act and subpart H of part 456 of this chapter.

(b) *Nursing facility services.* “Nursing facility services for individuals age 65 or older in institutions for mental diseases” means nursing facility services as defined in § 440.40 and in subpart B of

## § 440.150

part 483 of this chapter that are provided in institutions for mental diseases, as defined in § 435.1010 of this chapter.

[59 FR 56234, Nov. 10, 1994, as amended at 71 FR 39229, July 12, 2006]

### § 440.150 Intermediate care facility (ICF/MR) services.

(a) “ICF/MR services” means those items and services furnished in an intermediate care facility for the mentally retarded if the following conditions are met:

(1) The facility fully meets the requirements for a State license to provide services that are above the level of room and board;

(2) The primary purpose of the ICF/MR is to furnish health or rehabilitative services to persons with mental retardation or persons with related conditions;

(3) The ICF/MR meets the standards specified in subpart I of part 483 of this chapter.

(4) The recipient with mental retardation for whom payment is requested is receiving active treatment, as specified in § 483.440 of this chapter.

(5) The ICF/MR has been certified to meet the requirements of subpart C of part 442 of this chapter, as evidenced by a valid agreement between the Medicaid agency and the facility for furnishing ICF/MR services and making payments for these services under the plan.

(b) ICF/MR services may be furnished in a distinct part of a facility other than an ICF/MR if the distinct part—

(1) Meets all requirements for an ICF/MR, as specified in subpart I of part 483 of this chapter;

(2) Is clearly an identifiable living unit, such as an entire ward, wing, floor or building;

(3) Consists of all beds and related services in the unit;

(4) Houses all recipients for whom payment is being made for ICF/MR services; and

(5) Is approved in writing by the survey agency.

[59 FR 56234, Nov. 10, 1994]

## 42 CFR Ch. IV (10–1–09 Edition)

### § 440.155 Nursing facility services, other than in institutions for mental diseases.

(a) “Nursing facility services, other than in an institution for mental diseases” means services provided in a facility that—

(1) Fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital care, but whose mental or physical condition requires services that—

(i) Are above the level of room and board; and

(ii) Can be made available only through institutional facilities;

(2) Has been certified to meet the requirements of subpart C of part 442 of this chapter as evidenced by a valid agreement between the Medicaid agency and the facility for providing nursing facility services and making payments for services under the plan; and

(b) “Nursing facility services” include services—

(1) Considered appropriate by the State and provided by a religious non-medical institution as defined in § 440.170(b); or

(2) Provided by a facility located on an Indian reservation that—

(i) Furnishes, on a regular basis, health-related services; and

(ii) Is certified by the Secretary to meet the standards in subpart E of part 442 of this chapter.

(c) “Nursing facility services” may include services provided in a distinct part (as defined in § 483.5(b) of this chapter) of a facility other than a nursing facility if the distinct part (as defined in § 483.5(b) of this chapter)—

(1) Meets all requirements for a nursing facility;

(2) Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

(3) Consists of all beds and related facilities in the unit;

(4) Houses all recipients for whom payment is being made for nursing facility services, except as provided in paragraph (d) of this section;

(5) Is clearly identified; and

(6) Is approved in writing by the survey agency.

(d) If a State includes as nursing facility services those services provided



by a distinct part of a facility other than a nursing facility, it may not require transfer of a recipient within or between facilities if, in the opinion of the attending physician, it might be harmful to the physical or mental health of the recipient.

(e) Nursing facility services may include services provided in a swing-bed hospital that has an approval to furnish nursing facility services.

[59 FR 56234, Nov. 10, 1994, as amended at 64 FR 67052, Nov. 30, 1999; 68 FR 46071, Aug. 4, 2003]

**§ 440.160 Inpatient psychiatric services for individuals under age 21.**

“Inpatient psychiatric services for individuals under age 21” means services that—

(a) Are provided under the direction of a physician;

(b) Are provided by—

(1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

(2) A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

(c) Meet the requirements in § 441.151 of this subchapter.

[63 FR 64198, Nov. 19, 1998]

**§ 440.165 Nurse-midwife service.**

(a) “Nurse-midwife services” means services that—

(1) Are furnished by a nurse-midwife within the scope of practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse-midwife to the extent permitted by the facility; and

(2) Unless required by State law or regulations or a facility, are reimbursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. (See § 441.21

of this chapter for provisions on independent provider agreements for nurse-midwives.)

(b) “Nurse-midwife” means a registered professional nurse who meets the following requirements:

(1) Is currently licensed to practice in the State as a registered professional nurse.

(2) Is legally authorized under State law or regulations to practice as a nurse-midwife.

(3) Except as provided in paragraph (b)(4) of this section, has completed a program of study and clinical experience for nurse-midwives, as specified by the State.

(4) If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, meets one of the following conditions:

(i) Is currently certified as a nurse-midwife by the American College of Nurse-Midwives (ACNM) or by the ACNM Certification Council, Inc. (ACC).

(ii) Has satisfactorily completed a formal education program (of at least one academic year) that, upon completion qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives (ACNM) or by the ACNM Certification Council, Inc. (ACC).

(iii) Has successfully completed a formal educational program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and was practicing as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976 to July 16, 1982.

[47 FR 21050, May 17, 1982; 47 FR 23448, May 28, 1982, as amended at 55 FR 48611, Nov. 21, 1990; 61 FR 61486, Nov. 30, 1996]

**§ 440.166 Nurse practitioner services.**

(a) *Definition of nurse practitioner services.* Nurse practitioner services means services that are furnished by a registered professional nurse who meets a State’s advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

#### § 440.167

(b) *Requirements for certified pediatric nurse practitioner.* The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section.

(1) If the State specifies qualifications for pediatric nurse practitioners, the practitioner must—

(i) Be currently licensed to practice in the State as a registered professional nurse; and

(ii) Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services.

(2) If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must—

(i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

(ii) Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age.

(c) *Requirements for certified family nurse practitioner.* The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section.

(1) If the State specifies qualifications for family nurse practitioners, the practitioner must—

(i) Be currently licensed to practice in the State as a registered professional nurse; and

(ii) Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services.

(2) If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must—

(i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

(ii) Have a family nurse practice limited to providing primary health care to individuals and families.

#### 42 CFR Ch. IV (10–1–09 Edition)

(d) *Payment for nurse practitioner services.* The Medicaid agency must reimburse nurse practitioners for their services in accordance with § 441.22(c) of this subchapter.

[60 FR 19861, Apr. 21, 1995]

#### § 440.167 Personal care services.

Unless defined differently by a State agency for purposes of a waiver granted under part 441, subpart G of this chapter—

(a) *Personal care services* means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are—

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

(2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

(3) Furnished in a home, and at the State's option, in another location.

(b) For purposes of this section, *family member* means a legally responsible relative.

[42 FR 47902, Sept. 11, 1997]

#### § 440.168 Primary care case management services.

(a) Primary care case management services means case management related services that—

(1) Include location, coordination, and monitoring of primary health care services; and

(2) Are provided under a contract between the State and either of the following:

(i) A PCCM who is a physician or may, at State option, be a physician assistant, nurse practitioner, or certified nurse-midwife.

(ii) A physician group practice, or an entity that employs or arranges with physicians to furnish the services.

(b) Primary care case management services may be offered by the State—

(1) As a voluntary option under the State plan; or

(2) On a mandatory basis under section 1932 (a)(1) of the Act or under section 1915(b) or section 1115 waiver authority.

[67 FR 41115, June 14, 2002]

**§ 440.169 Case management services.**

(a) *Case management services* means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with § 441.18 of this chapter.

(b) *Targeted case management services* means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.

(c) [Reserved]

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes—

(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

(i) Taking client history.

(ii) Identifying the needs of the individual, and completing related documentation.

(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the

individual (or the individual's authorized health care decision maker) and others to develop those goals.

(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.

(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan.

(ii) Services in the care plan are adequate.

(iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

(e) Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

[72 FR 68091, Dec. 4, 2007, as amended at 74 FR 31196, June 30, 2009]

**§ 440.170 Any other medical care or medical care recognized under State law and specified by the Secretary.**

(a) *Transportation.* (1) “Transportation” includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

(2) Except as provided in paragraph (a)(4), transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency.

(3) “Travel expenses” include—

(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

(ii) The cost of meals and lodging en route to and from medical care, and while receiving medical care; and

(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant’s transportation, meals, lodging, and, if the attendant is not a member of the recipient’s family, salary.

(4) Non-emergency medical transportation brokerage program. At the option of the State, and notwithstanding § 431.50 (statewide operation) and § 431.51 (freedom of choice of providers) of this chapter and § 440.240 (comparability of services for groups), a State plan may provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide non-emergency medical transportation services for individuals eligible for medical assistance under the State plan who need access to medical care or services, and have no other means of transportation. These transportation services include wheelchair vans, taxis, stretcher cars, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation otherwise covered under the state plan.

(i) Non-emergency medical transportation services may be provided under contract with individuals or entities that meet the following requirements:

(A) Is selected through a competitive bidding process that is consistent with

45 CFR 92.36(b) through (i) and is based on the State’s evaluation of the broker’s experience, performance, references, resources, qualifications, and costs.

(B) Has oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and that transport personnel are licensed, qualified, competent, and courteous.

(C) Is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services.

(D) Is subject to a written contract that imposes the requirements related to prohibitions on referrals and conflicts of interest described at § 440.170(a)(4)(ii), and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or subcontract.

(ii) Federal financial participation is available at the medical assistance rate for the cost of a written brokerage contract that:

(A) Except as provided in paragraph (a)(4)(ii)(B) of this section, prohibits the broker (including contractors, owners, investors, Boards of Directors, corporate officers, and employees) from providing non-emergency medical transportation services or making a referral or subcontracting to a transportation service provider if:

(1) The broker has a financial relationship with the transportation provider as defined at § 411.354(a) of this chapter with “transportation broker” substituted for “physician” and “non-emergency transportation” substituted for “DHS”; or

(2) The broker has an immediate family member, as defined at § 411.351 of this chapter, that has a direct or indirect financial relationship with the transportation provider, with the term “transportation broker” substituted for “physician.”

(B) Exceptions: The prohibitions described at clause (A) of this paragraph do not apply if there is documentation to support the following:

(1) Transportation is provided in a rural area, as defined at § 412.62(f), and there is no other available Medicaid

participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(2) Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(3) Except for the non-governmental broker, the availability of other Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

(4) The broker is a government entity and the individual service is provided by the broker, or is referred to or subcontracted with another government-owned or operated transportation provider generally available in the community, if the following conditions are met:

(i) The contract with the broker provides for payment that does not exceed the actual costs calculated as though the broker were a distinct unit, and excludes from these payments any personnel or other costs shared with or allocated from parent or related entities; and the governmental broker maintains an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the brokerage program will be completely separate from any other program;

(ii) The broker documents that, with respect to the individual's specific transportation needs, the government provider is the most appropriate and lowest cost alternative; and

(iii) The broker documents that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for comparable services.

(C) Transportation providers may not offer or make any payment or other form of remuneration, including any kickback, rebate, cash, gifts, or service in kind to the broker in order to influence referrals or subcontracting for non-emergency medical transportation provided to a Medicaid recipient.

(D) In referring or subcontracting for non-emergency medical transportation with transportation providers, a broker may not withhold necessary non-emergency medical transportation from a Medicaid recipient or provide non-emergency medical transportation that is not the most appropriate and a cost-effective means of transportation for that recipient for the purpose of financial gain, or for any other purpose.

(b) *Services furnished in a religious nonmedical health care institution.* Services furnished in a religious nonmedical health care institution are services furnished in an institution that:

(1) Is an institution that is described in (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under section 501(a) of that section.

(2) Is lawfully operated under all applicable Federal, State, and local laws and regulations.

(3) Furnishes only nonmedical nursing items and services to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.

(4) Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients.

(5) Furnishes these nonmedical items and services to inpatients on a 24-hour basis.

(6) Does not furnish, on the basis of its religious beliefs, through its personnel or otherwise, medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients.

(7) Is not owned by, is not under common ownership with, or does not have an ownership interest of 5 percent or more in, a provider of medical treatment or services and is not affiliated with a provider of medical treatment or services or with an individual who has an ownership interest or 5 percent or more in a provider of medical treatment or services. Permissible affiliations are described in paragraph (c) of this section.

(8) Has in effect a utilization review plan that meets the following criteria:

(i) Provides for the review of admissions to the institution, duration of stays, cases of continuous extended duration, and items and services furnished by the institution.

(ii) Requires that the reviews be made by a committee of the institution that included the individuals responsible for overall administration and for supervision of nursing personnel at the institution.

(iii) Provides that records be maintained of the meetings, decisions, and actions of the utilization review committee.

(iv) Meets other requirements as CMS finds necessary to establish an effective utilization review plan.

(9) Provides information CMS may require to implement section 1821 of the Act, including information relating to quality of care and coverage determinations.

(10) Meets other requirements as CMS finds necessary in the interest of the health and safety of patients who receive services in the institution. These requirements are the conditions of participation found at part 403, subpart G of this chapter.

(c) *Affiliations.* An affiliation is permissible for purposes of paragraph (b)(7) of this section if it is between one of the following:

(1) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of an RNHCI and a provider of medical treatment or services.

(2) An individual who is a director, trustee, officer, employee, or staff member of an RNHCI and an another individual, with whom he or she has a family relationship, who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(3) The RNHCI and an individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and RNHCI.

(d) *Skilled nursing facility services for individuals under age 21.* “Skilled nursing facility services for individuals under 21” means those services specified in § 440.40 that are provided to recipients under 21 years of age.

(e) *Emergency hospital services.* “Emergency hospital services” means services that—

(1) Are necessary to prevent the death or serious impairment of the health of a recipient; and

(2) Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet—

(i) The conditions for participation under Medicare; or

(ii) The definitions of inpatient or outpatient hospital services under §§ 440.10 and 440.20.

(f) [Reserved]

(g) *Critical access hospital (CAH).* (1) CAH services means services that (i) are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of part 485 of this chapter), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary.

(2) Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48540, Oct. 1, 1981; 58 FR 30671, May 26, 1993; 62 FR 46037, Aug. 29, 1997; 64 FR 67051, Nov. 30, 1999; 72 FR 73651, Dec. 28, 2007; 73 FR 77530, Dec. 19, 2008; 74 FR 31196, June 30, 2009]

**§ 440.180 Home or community-based services.**

(a) *Description and requirements for services.* “Home or community-based services” means services, not otherwise furnished under the State’s Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.

(2) The services must meet the standards specified in § 441.302(a) of this chapter concerning health and welfare assurances.

(3) The services are subject to the limits on FFP described in § 441.310 of this chapter.

(b) *Included services.* Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:

- (1) Case management services.
- (2) Homemaker services.
- (3) Home health aide services.
- (4) Personal care services.
- (5) Adult day health services.
- (6) Habilitation services.
- (7) Respite care services.
- (8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.
- (9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

(c) *Expanded habilitation services, effective October 1, 1997—(1) General rule.* Expanded habilitation services are those services specified in paragraph (c)(2) of this section.

(2) *Services included.* The agency may include as expanded habilitation services the following services:

(i) Prevocational services, which means services that prepare an individual for paid or unpaid employment and that are not job-task oriented but are, instead, aimed at a generalized result. These services may include, for example, teaching an individual such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are distinguishable from noncovered vocational services by the following criteria:

(A) The services are provided to persons who are not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

(B) If the recipients are compensated, they are compensated at less than 50 percent of the minimum wage;

(C) The services include activities which are not primarily directed at teaching specific job skills but at underlying habilitative goals (for example, attention span, motor skills); and

(D) The services are reflected in a plan of care directed to habilitative rather than explicit employment objectives.

(ii) Educational services, which means special education and related services (as defined in sections 602(16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16 and 17)) to the extent they are not prohibited under paragraph (c)(3)(i) of this section.

(iii) Supported employment services, which facilitate paid employment, that are—

(A) Provided to persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting;

(B) Conducted in a variety of settings, particularly worksites in which persons without disabilities are employed; and

(C) Defined as any combination of special supervisory services, training, transportation, and adaptive equipment that the State demonstrates are essential for persons to engage in paid employment and that are not normally required for nondisabled persons engaged in competitive employment.

(3) *Services not included.* The following services may not be included as habilitation services:

(i) Special education and related services (as defined in sections 602(16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16) and (17)) that are otherwise available to the individual through a local educational agency.

(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(d) *Services for the chronically mentally ill—(1) Services included.* Services listed in paragraph (b)(8) of this section include those provided to individuals who have been diagnosed as being chronically mentally ill, for which the agency has requested approval as part of either a new waiver request or a renewal and which have been approved by CMS on or after October 21, 1986.

(2) *Services not included.* Any home and community-based service, including those indicated in paragraph (b)(8) of this section, may not be included in home and community-based service waivers for the following individuals:

(i) For individuals aged 22 through 64 who, absent the waiver, would be institutionalized in an institution for mental diseases (IMD); and, therefore, subject to the limitation on IMDs specified in § 435.1009(a)(2) of this chapter.

(ii) For individuals, not meeting the age requirements described in paragraph (d)(2)(i) of this section, who, absent the waiver, would be placed in an IMD in those States that have not opted to include the benefits defined in § 440.140 or § 440.160.

[59 FR 37716, July 25, 1994, as amended at 65 FR 60107, Oct. 10, 2000; 71 FR 39229, July 12, 2006]

**§ 440.181 Home and community-based services for individuals age 65 or older.**

(a) *Description of services.*— Home and community-based services for individuals age 65 or older means services, not otherwise furnished under the State's Medicaid plan, or services already furnished under the State's Medicaid plan but in expanded amount, duration, or scope, which are furnished to individuals age 65 or older under a waiver granted under the provisions of part 441, subpart H of this subchapter. Except as provided in § 441.310, the services may consist of any of the services listed in paragraph (b) of this section that are requested by the State, approved by CMS, and furnished to eligible recipients. Service definitions for each service in paragraph (b) of this section must be approved by CMS.

(b) *Included services.* (1) Case management services.

- (2) Homemaker services.
- (3) Home health aide services.
- (4) Personal care services.
- (5) Adult day health services.
- (6) Respite care services.

(7) Other medical and social services requested by the Medicaid agency and approved by CMS, which will contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

[57 FR 29156, June 30, 1992]

**§ 440.185 Respiratory care for ventilator-dependent individuals.**

(a) “Respiratory care for ventilator-dependent individuals” means services that are not otherwise available under the State's Medicaid plan, provided on a part-time basis in the recipient's home by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State) to an individual who—

(1) Is medically dependent on a ventilator for life support at least 6 hours per day;

(2) Has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;

(3) Except for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the State plan;

(4) Has adequate social support services to be cared for at home;

(5) Wishes to be cared for at home; and

(6) Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual.

(b) For purposes of paragraphs (a)(4) and (5) of this section, a recipient's home does not include a hospital, NF, ICF/MR or other institution as defined in § 435.1010 of this chapter.

[59 FR 37717, July 25, 1994, as amended at 71 FR 39229, July 12, 2006]

**Subpart B—Requirements and Limits Applicable to All Services**

**§ 440.200 Basis, purpose, and scope.**

(a) This subpart implements the following statutory requirements—

(1) Section 1902(a)(10), regarding comparability of services for groups of recipients, and the amount, duration, and scope of services described in section 1905(a) of the Act that the State plan must provide for recipients;